

## QUALIFIED MEDICARE BENEFICIARY (QMB) REFERRAL

APPLICANT NAME:	ADDRESS:
SSN:                                  DOB:                                  SEX:	
MEDICARE HIC#:	
PHONE:	

The person named above is an applicant for the Qualified Medicare Beneficiary (QMB) Program. Medicare eligibility status must be confirmed before the State can begin paying his/her Medicare premiums, deductibles and coinsurance.

**INSTRUCTIONS: COUNTY WELFARE DEPT. – Please complete Part I.  
SSA – Please enroll applicant in Medicare and complete Part II. Have the applicant  
return this form to the county.**

**PART I COMPLETED BY COUNTY DEPARTMENT OF SOCIAL SERVICES/WELFARE.**

- ☐ Currently eligible for Part B; however, must apply for **conditional** Part A.
- ☐ Not currently enrolled in either Medicare Part A or Part B. Please enroll the applicant in **conditional** Part A and Part B (if eligible)
- ☐ Medicare status unknown

COUNTY WELFARE ADDRESS:	EW NAME/EW#:	PHONE:	DATE:

**PART II COMPLETED BY SOCIAL SECURITY ADMINISTRATION**

- ☐ Eligible for **conditional** Medicare Part A effective \_\_\_\_\_. Please evaluate for QMB eligibility.
- ☐ Currently receiving Medicare Part A.
- ☐ Must reapply during the general enrollment period.
- ☐ Not eligible for Part A or B because:

SSA SIGNATURE:	TITLE:	PHONE:	DATE:
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